Solano Napa Counties Electrical Workers Benefit Funds
PO Box 1306
San Ramon, CA 94583
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Telephone: (925) 208-9980 or Toll Free (866) 544-9880

ENROLLMENT FORM

CHECK ALL THAT APPLY: ☐ **New Enrollment** ☐ **Adding Dependents** ☐ **Address Change**

EMPLOYEE'S FULL NAME: _____ S.S.#: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP _____ DATE OF BIRTH _____ SEX: _____Male _____Female

PHONE NUMBER: (_____)_____CURRENT STATUS: (circle one) Active Retired Disabled COBRA

Marital Status: (circle one) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Medicare Claim Number including the letter(s) that follows the number
(only applies when member, spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member #: _____ Spouse# _____ Dependent Name: # _____

DEPENDENTS – (Including Spouse)

(**ATTACH LEGAL DOCUMENTATION THAT APPLIES**: birth certificate(s), marriage certificate, adoption papers, guardianship papers, divorce papers and proof of support.)

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

DATE: _____MEMBER SIGNATURE _____

PLEASE RETURN THIS FORM TO THE ABOVE ADDRESS. THANK YOU.
YOU MUST COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

OVER

OTHER INSURANCE INQUIRY

Please complete and return this form, if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

General Information:

Member's Name: _____ SSN or ID#: _____

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Does this plan include **Medical** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Medical Carrier: _____

Effective Date: _____Termination Date (if applicable): _____ Policy/Group Number: _____

Does this plan include **Dental** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____

Effective Date:_____ Termination Date (if applicable): _____ Policy/Group Number:_____

Does this plan include **Vision** coverage? YES NO If yes, is this plan an: HMO or PPO

If yes, name of Vision Carrier: _____

Effective Date: _____Termination Date (if applicable): _____ Policy/Group Number: _____

Coverage is (circle): Single Family

Children are covered until age: _____

List Covered Dependents:

1. _____ 3. _____
2. _____ 4. _____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

_____ _____

Member Signature **Date**